HHA PPS MAILBOX QUESTIONS
VOLUME V: May 2001 – Batch 1

The questions below, which in some cases have been paraphrased, were sent to *"e-mailto: HHPPS@HCFA.gov"* during the period referenced above. It is our intention to continue to answer questions that come into that mailbox in monthly batches, and post those answers at: *"http://www.hcfa.gov/medlearn/refhha.htm"*. This batch of questions was pulled from the mailbox prior to June 1, 2001. In cases where time is needed to consult internal experts, multiple batches of answers may be released under the same Volume number (same time period or month). Note that questions without broad applicability have been/will be answered/referred individually.

Questions are grouped by topic and not repeated. However, each batch of questions will be listed by topic in order at the beginning of each batch of answers, and a table of cross-references will follow.

Questions by Major Topic

Alphabetical Cross-reference Topics

Therapy Threshold: 7
Transfer: 4

General Terms/Acronyms *(Need to edit against hardcopy)*

The following terms/acronyms may not be spelled out/explained above or elsewhere in this document:

CMS = The Centers for Medicare and Medicaid Services, new name of HCFA (below).
HH = Home Health
HHA = Home Health Agency
HCFA = Health Care Financing Administration, previous name of the federal agency administering Medicare and Medicaid. Note: The name of the agency was changed to CMS (above).
HCPCS = HCFA Common Procedure Coding System, individual codes representing medical services or items in Form Locator 44 of Medicare claims
HHRG = Home Health Resource Group, the payment group for HH PPS episodes
HIPPS = Health Insurance PPS, a code representing a PPS payment group on a Medicare institutional claim, placed in Form Locator 44
MSA = Metropolitan Statistical Area, a series of codes representing geographic locations put on Medicare HH claims so that payment is commensurate with the location in which services are delivered.
OASIS = Outcome and Assessment Information Set. The standard assessment instrument required by CMS for use in delivering home care.
PPS = Prospective Payment System. A pre-determined method of fee for service payment of bundled services, as opposed to cost reimbursement of individual services, used to pay many types of Medicare providers (hospitals, SNFs, etc.); Medicare pays for home care under a plan of care through a PPS since October 1, 2000.
RAP = Request for Anticipated Payment. The first of two transactions submitted on a UB92 claim form to get the first of two split percentage payments for a HH PPS episode.
RHHI = Regional Home Health Intermediary. Medicare fiscal intermediary specializing in the processing of hospice and home health claims.
SNF = Skilled Nursing Facility.

CONSOLIDATED BILLING

Q1: How would I submit a claim with outpatient physical therapy (PT) included in the episode? Does it have to show up as just regular PT visits or outpatient PT visits?

A1: All physical therapy services provided within a home health PPS episode, whether they are supplied in the home or required when transporting the beneficiary to equipment too cumbersome to use in the home, are submitted identically on the final claim for the episode. They are coded as follows on a line

item of a HH PPS claim: revenue code 42x in Form Locator (FL) 42, HCPCS code G0151 in FL44, the date of service in FL45, service units representing the number of 15 minute increments in the service in FL 46, and a charge amount in FL47.

RATES and PAYMENT

Q2: When a patient is admitted to a HH facility, an OASIS start of care (SOC-timepoint 1) is completed. An agency receives 60% of the allotted money for this episode after the RAP has been submitted. If a patient is discharged when the 60-day episode is up, the HHA then receives the remaining 40%. Now, if a patient is transferred into an inpatient facility, a transfer OASIS (timepoint 6) is completed. This patient is now considered on hold with that agency so that the hospital can bill for their services. When the patient is discharged from the inpatient facility and returns to the HHA before the end of the episode, the HHA completes a resumption of care OASIS (timepoint 3), and service provided by the HHA can continue. When the patient is finally discharged from the agency, and a discharge OASIS is completed, final reimbursement is received by the HHA.

We believe that if the patient's hospitalization during the episode of care exceeds the amount the HHA should have been reimbursed, the money that was overpaid is then recouped from the HHA. I need this scenario explained, to make sure I understand this process completely.

A2: The scenario you describe could result in one of two outcomes on your claim. If the patient returned from the hospital within the episode, and the resumption of care OASIS did not result in a change in the payment group (the HIPPS code) for the episode, your billing and payment for the episode would be unaffected by the inpatient stay that occurred. If the resumption of care OASIS indicated that the HIPPS code did change and there was a change in physician orders, you may have to report a significant change in condition (SCIC) on the claim. It appears that this is the case you are describing in your question.

The recoupment you describe could result from the fact that the days the beneficiary spent in the hospital would not be counted in the payment calculation for the SCIC. Costs of an interim hospitalization are not ever considered in making a determination of what a HHA should be paid for an episode, only the days away from the HHA affect the SCIC calculation. If the SCIC calculation indicates that payment for the episode would decrease as a result of reporting the SCIC and the HIPPS code weight increased (i.e., the beneficiary's condition worsened), the SCIC does not have to be e reported. The case you are describing may be one in which you could exercise the option not to the report the SCIC. Also note that, other than dates of transfer, the HHA and hospital should not be billing for the same date of service in an episode period.

Q3: When a patient is admitted, the initial RAP is created, and for that first RAP you will receive 60% of that RAP payment until the final claim is created. If this is not the

patient's first RAP and the patient is an ongoing case, does the reimbursement for the RAP fall to 50%-50% instead of 60%-40%?

A3: You are correct that the RAP for the initial HH PPS episode is paid 60% of the episode payment, and RAPs for subsequent episodes of continuous care are paid 50% of the episode payment. In Medicare systems, initial episodes are identified when the RAP "from" date (in form locator [FL] 6 of the UB-92 claim form) and the admission date (in FL 17) are identical. In circumstances where there is a break in services between episodes (for example, when the beneficiary was in the hospital for a period of time that spans the end of one episode and the beginning of the next) the RAP should again be billed as an initial episode. The from and admission dates would again match, and the RAP would receive a 60% payment.

Q4: According to the HH PPS Training Manual, if the payer source changes during a 60-day episode, a new OASIS must be completed and a new 60-day episode begins. The first episode is closed out and payment is made according to a PEP adjustment. My questions is how is this PEP adjustment claim coded? Do HHAs use a patient status code of 06 even though this means 'transfer from one agency to another'? Is there another patient status code that informs the payer that a change in coverage has taken place?

A4: Patient status code 06 is used in cases when the Medicare payer source changes (traditional Medicare to Medicare +Choice), to indicate the 'transfer' of payer source. A specific patient status code to describe this situation has not yet been developed. Patient status 06 is used in all cases in which a PEP payment is made, including changes of intermediary, Medicare payer source and agency ownership. [Revised September 18, 2001]

MERGERS and OWNERSHIP

Q5. We will be converting a branch home health agency into a parent soon. There is some confusion regarding discharging the patients from the branch and readmitting them to the new parent when we receive notice of the certification date (start of care date has to be after the certification date.) This situation is similar to Question 31 in Volume 1, Batch 1 of the Mailbox Questions, except there is no change in ownership. Do we:

1) Discharge and readmit the patients on the next billable visit?

2) Wait until the end of the episode and discharge and readmit?

In this particular situation, the admitting agency is related to the discharging party. The regulations address discharge to another home health agency that is related as not creating a PEP.

The answer to Question 31 also states that the RAPs can be submitted for the new episodes on the date from which the provider number becomes effective. However, the

provider number does not arrive for several weeks and it takes several more weeks for the intermediary to set the agency up for electronically transmitting

A5. The merger of one provider into another provider constitutes a change of ownership. The agency that is merging into another will receive partial episode payment (PEP) adjustments for all episodes that will continue beyond the date of sale or merger. These adjustments are prorated by the number of days from the first billable date in such episodes to the last billable date on or before the date of sale. Since the agency merging into another will no longer provide care under its own Medicare provider number, all patients would have to be discharged under this number. The other agency this agency merged into would then obtain new certifications, perform new OASIS assessments and open new episodes under its own Medicare provider number after the merger. The closed agency is required to file a terminating cost report.

While it is true that Section I.C.4. of the HH PPS final rule does state: "[CMS] will not apply the PEP adjustment if the transfer is between organizations of common ownership", further clarification is found at III.I. in this same rule:

> ***If an HHA has a significant ownership interest as defined in Section 424.22 [of the Code of Federal Regulations], then the PEP adjustment would not apply. Those situations would be considered services provided under arrangement on behalf of the originating HHA by the receiving HHA, with the ownership interest until the end of the episode. The common ownership exception to the transfer PEP adjustment does not apply if the beneficiary moved out of their MSA or non-MSA during the 60-day episode before the transfer to the receiving HHA. The transferring HHA not only serves as the billing agent, but must also exercise professional responsibility over arranged-for services in order for the services provided under arrangement to be paid.***

Clearly, in order to qualify for this exception, both involved agencies must be continuing in business since one is designated to act as the "billing agent" exercising professional responsibility over the other for the entire episode period. In the case you raise, one agency is closing, and therefore this agency cannot continue to accept responsibility for billing or other professional oversight.

Also, since the agency remaining in business is implied in your question to have been operating at some point prior to the merger, it is unlikely that a wait for a provider number to become effective is involved. However, you are correct that Medicare cannot be billed until the date a provider number becomes effective. You may, however, bill back to that date if there is lag between the effective date and notification or activation of the provider number in RHHI systems. You may bill back to the effective date for the entire timely filing period for any RAP or claim.

You should still obtain certification and perform timely OASIS assessments whether or not notification of the effective date has been received.

DIAGNOSIS CODING

Q6. Please clarify the directive to Home Health Agencies that the diagnosis on the OASIS assessment, 485 and UB92 must match. Does this mean all of the diagnoses, i.e., the principal as well as all the secondary diagnosis? Is the real concern here that the primary and the 1st secondary match because of the effect the HHRG? The reason I ask is:

- the 485 has a place for procedure/surgical codes and V-codes --OASIS does not accept these so there can never be a perfect match.
- OASIS accommodates 1 principal and 5 secondary diagnoses
- 485 accommodates 1 principal and 4 secondary + additional to the 487 (per our vendor software capability)
- UB-92 accommodates 1 principle and 8 secondary and 1 E-Code (way more than the 485/487 or OASIS accommodates and/or permits by regulation.

Please provide resource/evidence we can reference in addition/in support of your response.

A6. Section 475.2 of the Medicare Home Health Agency manual stipulates these diagnoses must match, and describes in the instructions for FL 68-75 how to accommodate the varying requirements of the three forms. All codes that are on the OASIS must be in the 485 plan of care. Codes that cannot be reported on OASIS can be reported on the 485 in the narrative section, form item 21. This narrative section can also be used to accommodate codes in excess of the four specified fields for other diagnoses. All diagnosis codes on the 485 (those reported on OASIS plus any additions) must be reported on the claim, which as you point out has sufficient fields for most cases. The primary diagnosis (whether coded with single or multiple codes) should be the same on all three forms. The sequence of codes should follow ICD-9 guidelines for reporting manifestation codes. Therefore, if a manifestation code is part of the primary diagnosis, the first two diagnoses should match and appear in the same sequence, on all three forms. Beyond these guidelines, Medicare does not require that the sequence of the codes on the three forms must be identical. Since E-codes and procedure codes (other than CPT/HCPCS) are not required on home health claims, these create no conflict.

OASIS, COVERAGE and MEDICAL REVIEW

Q7. I have reviewed the many HHPPS questions and answers, and I am not able to locate a definite answer to my question. This question also comes up with the updated

OASIS correction policy. At the start of care, you determine that a patient meets the definition for high therapy utilization, and you mark "YES" to question M0825 on OASIS, and then the patient only requires 6 therapy visits. You have already submitted your RAP with the HHRG for high therapy (RAP payment received), and now you are submitting your final claim. I realize that the HHRG will automatically be adjusted down on the final claim, and the low therapy payment with adjustment to the RAP will be made.

Are agencies required to go back to the OASIS and make a correction to M0825 in the example above (change "YES" to a "NO"), and then transmit the correct assessment to the state data base? Please respond as our company has differing views on this subject.

A7. You are correct that no billing action is necessary. Since the RAP is overlaid by the claim to form a complete episode record in Medicare claims systems, you do not have to cancel the original RAP and resubmit it. The HIPPS code representing the HHRG or payment group for the entire episode will be the final HIPPS appearing for the remittance for the claim after downcoding has occurred.

If the therapy need was over-estimated at the beginning of the episode, and there was no clinical change in the patient's health status, you should make a note in the patient's record as to the difference between therapy originally estimated and therapy actually delivered. However, it is not necessary to correct the original assessment at M0825 (i.e. change the Yes to a No) to update the HHRG.
[Revised November 1, 2001]